Suffolk County Department of Social Services
FCSA Child Care Bureau

Confidential Inquiry on Employment

(The Employer must complete all employment related sections and sign the form)

DATE	EMPLOYEE	SSN	DSS CASE #
DSS CASE NAME AND ADDRESS		RETURN FORM TO: ☐ EMPLOYEE OR ☐ LISTED ADDRESS ATTN: _____ ☐ DSS FAX _____	

EMPLOYEE START DATE:	IF EMPLOYEE IS NO LONGER WORKING, EXPLAIN WHY, AND PROVIDE LAST DATE WORKED: _____ LAST DAY:_____	REQUESTED RETURN DATE:

An eligibility requirement for receipt of Childcare is verification of employment. Section 143 of the Social Welfare Law states :
"If requested by an authorized representative...the officials or executives of any corporation or partnership, and all employers of labor of any kind doing business within the State of New York, shall furnish to such representative or authority, information relating to wages, salaries, earnings or other income of any applicant for, or recipient of childcare ...or of any relative legally responsible for the support of such applicant or recipient."

EARNINGS FOR LAST 12 WEEKS OF EMPLOYMENT (TO BE COMPLETED BY EMPLOYER)				
PAY PERIOD		**GROSS PAY** (Before Deductions)	**TIPS/ COMMISSION**	**OTHER (SPECIFY)**
FROM	**TO**			

Start Date:	Title:	Hourly Wage:	Avg # Hours Worked:
Pay Cycle: ___Weekly; ___Bi-weekly; ___Semi-Monthly; ___Monthly (___1st ___15th ___30th); Other, Specify: _____			

Check the Days of the Week Employee Works:	Mon ☐	Tues ☐	Wed ☐	Thurs ☐	Fri ☐	Sat ☐	Sun ☐
Indicate time usually worked (i.e. 9 am – 5 pm):							

Name of Employer: _____

Address of Employer: _____

Local Job Site Contact Person: _____ Phone:_____

Employer's Signature: _____ Title:_____ Date:_____

FORM CCB-6010-004 (Rev. 04/2015)

P.O. BOX 18100
HAUPPAUGE, NY 11788-8900

www.suffolkcountyny.gov/departments/socialservices
Child Care Unit Fax #: (631) 854-3331